# Authorization for Release of Information – Adult

_____

Name of Treatment Facility

_____

Address of Treatment Facility

This will authorize _____

Name of Person

To release to _____ Ivone Juell, MA, MA, RPC, MPCC-S _____

Name (Counsellor)

_____ Door of Hope Counselling Clinic Inc. 2606 Kingsway Ave. Port Coquitlam BC V3C 1T6 _____

Name & Address of Treatment Facility

Information from the clinical record maintained while I and / or persons under my guardian was / are a client at the above facility during _____

Dates

For the purpose of _____

_____

_____

_____

I acknowledge that information to be released may include material concerning drug and alcohol and mental health treatment, which is protected by federal law. My signature below authorizes release of all the above noted information to _____, counsellor. **I understand that all information received will be treated as confidential**.

**I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without any express revocation.**

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Client Name | Date | Counsellor Name | Date |